

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Pilot Butte Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1876 NE Highway 20 Bend, OR 97701	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>38139</p> <p>Based on interview and record review it was determined the facility failed to report to the State Agency an unwitnessed fall with serious bodily injury for 1 of 3 sampled residents (#101) reviewed for accidents. This placed residents at risk for additional accidents and potential abuse. Findings Include:</p> <p>Resident 101 was admitted to the facility in 8/2023, with diagnoses including hip fracture, history of falls, and dementia with cognitive decline.</p> <p>An Incident Report dated 8/31/23 indicated a nurse was called to Resident 101's room because of a fall. The resident was found lying in bed with a skin tear above the left eye and another on the right elbow. There were no witnesses listed. The nurse found bruising and excess fluid when she assessed the elbow. The resident was sent out to the hospital.</p> <p>A 9/1/23 at 3:20 PM, Alert Progress Note indicated Resident 101 was on alert charting due to multiple recent falls. The most recent fall was on 8/31/23 and resulted in a fractured elbow requiring surgery and a laceration above the eye.</p> <p>A review of the medical record for Resident 101 revealed no evidence a Facility Reported Incident, for the fall with a major injury, was submitted by the facility to the State Survey Agency.</p> <p>On 4/16/24 at 11:41 AM, Staff 1 (Administrator) confirmed the facility did not notify the state agency of the resident's fall with a major injury.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>38139</p> <p>Based on interview and record review it was determined the facility failed to thoroughly investigate an unwitnessed fall with a major injury and rule out potential abuse or neglect for 1 of 3 sampled residents (#101) reviewed for falls. This placed resident at risk for additional falls and potential abuse. Findings include:</p> <p>Resident 101 was admitted to the facility in 8/2023, with diagnoses including hip fracture and repeated falls.</p> <p>Resident 101's care plan revised on 9/25/23, indicated the resident was at risk for falls, had a history of falls prior to admission and had multiple recurrent falls while at the facility despite fall interventions in place.</p> <p>An Incident Report dated 8/31/23, indicated a nurse was called to Resident 101's room because of a fall. The resident was found lying in bed with a skin tear above the left eye and another on the right elbow. The resident said she/he could not extend the arm all the way. The resident did not remember hitting her/his head but stated she/he must have since there was a skin tear to her/his left eyebrow. There were no witnesses listed. The nurse found bruising and excess fluid when she assessed the elbow. The resident was sent out to the hospital.</p> <p>A 9/1/23 at 3:20 PM Alert Progress Note, indicated Resident 101 was on alert due to multiple recent falls. The most recent fall was on 8/31/23 and resulted in a fractured elbow requiring surgery. The resident also had a laceration above the eye.</p> <p>Review of the 8/31/23 facility's fall investigation, contained no new or additional investigation information. The investigation was not thorough and did not address the following:</p> <ul style="list-style-type: none"> -How did the resident get back into bed? -Was the resident's roommate a witness? -Why was there no statement from the roommate? -Was the CNA interviewed or written statement obtained? -How long since the resident was last checked on? -Why was the resident trying to go to the bathroom alone when she/he was care planned for assistance? -How did the wheelchair get away from the resident? -Were the care planned interventions implemented? <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There was no information in the document related to the resident's fractured elbow or eye laceration.</p> <p>-There was no indication that abuse and neglect were ruled out or how they were ruled out.</p> <p>-There was no documentation the unwitnessed fall with a major injury was reported to the state agency.</p> <p>On 4/16/24 at 11:41 AM, Staff 1 (Administrator) confirmed the investigation document provided for Resident 101's fall with a major injury was not complete or thorough. Staff 1 had no additional information to provide.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38139</p> <p>Based on interview and record review it was determined the facility failed to ensure the environment was free of potential accident hazards for 1 of 3 sampled residents (#103) reviewed for accidents. This placed the residents at risk for potential accidents. Findings include:</p> <p>Resident 103 was admitted to the facility in 7/2022 with diagnoses including neck fracture and a history of falls.</p> <p>A Facility Reported Incident Form dated 8/16/22 indicated on 8/15/22 at 8:06 PM a CNA found Resident 103 on the floor in her/his bathroom. The nurse who arrived to assess the resident indicated the toilet was not attached to the floor. The toilet was on its side with a four wheel [NAME] beside it. No signs were placed on the resident's door or the bathroom door to not use the toilet. No evening staff members were notified the toilet was not secured to the floor.</p> <p>A written statement dated 8/15/22 by the facility Maintenance Director indicated the maintenance department was notified the toilet in Resident 103's bathroom was very loose because the floor mounting screws were stripped. He pulled the toilet, put it on a four wheel [NAME] and put it against the wall in preparation for repairs the next morning. The statement indicated he did not make sure there were Out of Order signs posted.</p> <p>On 4/10/24 at 2:35 PM Staff 1 (Administrator) confirmed the Maintenance Director failed to lock the door, notify evening staff, or place signage to prevent use of the toilet.</p>